Virginia Department of Medical Assistance Services Date 03/2007

Unit Dose Request Form

Thank you for your request to be certified as a Unit Dose System Dispenser (**the pharmacy shall dispense not more than a seven-day supply of a drug in a solid, oral dosage form at any one given time.**). Additional reimbursement(s) for unit dose packaged products is available once the Department of Medical Assistance Services has certified the pharmacy as a unit dose dispenser and if the recipient is certified as a skilled or intermediate care patient. Each dose must be packaged individually; Each dose must be labeled identifying the drug and strength; Packaging/labeling must meet the requirement established by the Virginia Board of Pharmacy for unit-dose dispensing; Up to a seven day supply can be dispensed to the facility; A multiple-day dose (e.g., greater than seven days and up to 30-days supply **system** does **not** qualify for unit-dose certification). The facility must be identified as a nursing facility. The unit dose package is then placed in the patient's bin or drawer which is labeled only with the patient's name and location and delivered daily to the nursing home to qualify for unit dose dispensing. Unit-dose dispensing to a home for the aged, adult day care residence, or assisted living facility does **not** qualify for unit-dose certification.

Type or print the information requested below.

Pharmacy Name _____ Pharmacy NPI # _____

Physical Address _____Telephone #_____

City, State, Zip _____

I. Be advised this pharmacy provides unit-dose pharmaceutical services to the following listed nursing home facilities:

	Name of Facility	Address
1.		
2.		
3.		
4.		
5.		
6.		

II. The unit-dose system utilized by this pharmacy is known commercially as _____.

III. Currently, the following dosage forms are provided in unit-dose packages:

Type	Yes	No	Type	Yes	No
Capsules and tablets			Suppositories		
Oral liquids			Others		
Others			Others		

IV. Submitted by: Name Position Date

V. I certify that _____ Pharmacy **agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of DMAS as from time to time amended.**

(Signature of Owner or Official) (Date)

Official Use ONLY: Approved ☐ Denied ☐ Signature: _____ Date:_____